# APPENDIX A – UNPUBLISHED OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT DATED AND DECIDED FEBRUARY 2, 2004

**UNPUBLISHED**

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

**No. 03-1698**

LEON HARRELL,

Plaintiff – Appellant,

versus

CNA INSURANCE COMPANIES; CONTINENTAL CASUALTY COMPANY; QUORUM HEALTH GROUP, INCORPORATED I d/b/a Carolinas Hospital System; QHG OF SOUTH CAROLINA, INCORPORATED, d/b/a Carolinas Hospital System; CAROLINAS HOSPITAL SYSTEM GROUP LONG TERM DISABILITY PLAN,

Defendant - Appellees

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Appeal from the United States District Court for the District of South Carolina, at Florence. C. Weston Houck, Senior District Judge. (CA-99-292-4-12)

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Submitted: December 22, 2003 Decided: February 2, 2004

Before WILKINSON, MOTZ, and GREGORY, Circuit Judges.

Affirmed by unpublished per curiam opinion.

Chalmers C. Johnson, CHALMERS JOHNSON LAW FIRM, Charleston, South Carolina, for Appellant. John E. Schmidt, III, Kerry B. McTigue, NELSON MULLINS RILEY & SCARBOROUGH, L.L.P., Columbia, South Carolina, for Appellees.

Unpublished opinions are not binding precedent in this circuit. See Local Rule 36(c).

PER CURIAM:

Leon Harrell appeals the district court's orders denying his disability claim under the Employee Retirement Income Security Act of 1974, 29 U.S.C. SS 1001-1168 (2000), his request for sanctions under 29 U.S.C. § 1132, his requests for attorneys, fees and costs, and his request for reconsideration. We have reviewed the record and find no reversible error. Accordingly, we affirm for the reasons stated by the district court in its various orders. See Harrell v. CNA Insurance Co., No. CA-99-292-4-12 (D.S.C. filed Jan 15 and entered Jan. 16, 2003; Jan. 21, 2003; May 14, 2003; May 15, 2003). We dispense with oral argument because the facts and legal contentions are adequately presented in the materials before the court and argument would not aid the decisional process.

AFFIRMED

**APPENDIX B – ORDER FROM U.S. DISTRICT COURT, JUDGE WESTON HOUCK, ENTERED JANUARY 16, 2003**

**JAN 15 2003**
LARRY W. PROPES,

IN **THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF SOUTH CAROLINA**
**FLORENCE DIVISION**

| | | |
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| **LEON HARRELL,** | ) | |
| **Plaintiff,** | ) | **Civil Action No. 4:99-0292-12** |
| | ) | |
| VS. | ) | |
| | ) | |
| **CNA INSURANCE** | ) | |
| **COMPANIES,** | ) | **ORDER** |
| **CONTINENTAL** | ) | |
| **CASUALTY COMPANY,** | ) | |
| **QUORUM HEALTH** | ) | |
| **GROUP, INC.,** | ) | |
| **AND QHG OF SOUTH** | ) | |
| **CAROLINA, INC., both** | ) | |
| **d/b/a CAROLINA'S** | ) | |
| **HOSPITAL SYSTEM** | ) | |
| **GROUP LONG TERM** | ) | |
| **DISABILITY PLAN** | ) | |
| **Defendant.** | ) | |
| | ) | |

On December 16,1998, Leon Harrell ("Plaintiff') brought this claim in the court of common pleas for Florence County, South Carolina, alleging two causes of action against CNA Insurance Companies, Continental Casualty Company, Quorum Health Group, Inc., and QHG of South Carolina, Inc. ("Defendants"). Plaintiff alleged

causes of actions for termination of his benefits under 29 U.S.C. § 1132(a)(1) and for damages under 29 U.S.C. § 1132(c)(1) for violation of 29 U.S.C. § 1024(b)(4). On February 1, 1999, defendants removed the case to this Court. In their answer, CNA and Continental Casualty asserted a counterclaim for overpayment to plaintiff. On June3O, 2000-defendants moved for summary judgment on their counterclaim, and on July25, 2000, the Court granted the unopposed motion.

The parties subsequently agreed to try plaintiff's claims on submissions. After reviewing the exhibits, the evidence presented, and the briefs submitted by the parties, the Court makes the following Findings of Fact and Conclusions of Law.

## I. FINDINGS OF FACT

1. Prior to December 1996, Plaintiff was a Cardiac Catheterization Lab Technician at Carolinas Hospital ("Carolinas")'m Florence, South- Carolina. Carolinas is owned by Quorum Health Group, Inc. and QHG of South Carolina, Inc. (collectively referred to as "Quorum").

2. Quorum contracted with Continental Casualty Company, known by· the trade name "CNA Insurance" ("C.IA") to provide an optional Long Term Disability program to its employees. Plaintiff purchased this insurance.

3. Under the insurance policy, "[t]otal disability" meant that because of injury or sickness [the employee] is

(1) continuously unable to perform the substantial and material duties of his regular occupation

(2) under the regular care of a licensed physician other than himself; and

(3) not gainfully employed in any occupation for which he is or becomes qualified by education, training, or experience.

4. The policy stated that "[the Administrator [Quorum] and other Plan fiduciaries have discretionary authority to interpret the terms of the Plan and to

determine eligibility for and entitlement to benefits in accordance with the Plan." CNA was a fiduciary of the policy.

5. In December 1996, plaintiff applied for long term disability benefits. He was suffering from osteomyelitus' of his left heel, sarcoidosis of his lungs and joints,' diabetes, high blood pressure, and depression. In support of his claim for disability, plaintiff submitted medical records, including test results and medical evaluations to CNA detailing his health problems. At that time he was being treated by Drs. Gary B. Anderson, a pulmonologist, and J.P. Booth, a family practitioner

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'Osteomyelitis is an inflammation of bone.

2Sarcoidosis is an inflammation of tissue.



6. December 18, 1996 was plaintiff's last day of work at Carolinas. Plaintiff's policy contained a 150-day elimination period. He was therefore not eligible to receive benefits until May 17, 1997.

7. On April 11, 1997, CNA notified plaintiff by letter that his claim for benefits had been approved. It also advised plaintiff that "[t]he policy requires that you... provide proof of ... continuing disability. Therefore, periodic claim reports will be sent to you.... To assure prompt payment of future benefits, please have the claim report completed as required and return it to us when requested."

8. Plaintiffs monthly benefit was 60% of his salary, or $2,342.08. This benefit, however, was subject to reduction by **the** amount CNA was entitled to withhold due to plaintiffs Social Security benefits. See Order of June 30, 2000.

9. Plaintiff s payments under the policy started on June 18, 1997. CNA appointed a disability specialist, Pam Ward, and a nurse case manager to review plaintiff's disability status on an ongoing basis.

10. At some point after his claim was approved, plaintiff stopped seeing Dr. Anderson, and instead relied on Dr. Booth to treat all of his infirmities and give updates to CNA. Dr. Booth submitted periodic reports and plaintiff continued receiving benefits until the spring of 1998.

11. In his April 13, 1998 report, Dr. Booth noted that plaintiff "has had significant lung disease in the past, but fortunately his [chest x-rays] have improved. He has problem [sic] with depression which is reasonably controlled." Dr. Booth also noted that plaintiff s progress had improved, but he increased plaintiff s dosage of Prednisone, the drug used to treat sarcoidosis, and



maintained his already-high dosage of Motrin. On CNA's disablity form, Dr. Booth checked "Yes" to the question "Is patient now totally disabled?" He checked "No" to the question that stated "Do you expect fundamental or marked change in the future?"

12. Upon reviewing the report, Ms. Ward and the nurse case manager, Ms. Teresa Barressi, determined that plaintiff no longer met the policy's requirement of total disability. On May 15, 1998, Ms. Ward sent a letter to plaintiff informing him that CNA no longer considered him disabled under the policy and explaining his rights to appeal. She stated that "[the medical information ... fails to document medical evidence of a continuously disabling physical or mental impairment that meets the definition of total disability. Verification that a medical condition exists does not confirm disability." The letter informed plaintiff of his right to appeal the decision and instructed plaintiff to send the appeals committee "objective medical information relevant to the issues and time period surrounding [his] claim."

13. On May 20, 1998, Dr. Booth, at plaintiff s request, called Ms. Barresi. Her notes of this conversation reveal that Dr. Booth stated that he was familiar with the requirements of plaintiff's job and that plaintiff could return to work. She also noted that Dr.

Booth agreed with Ms. Barresi's statement that returning to work would be therapeutic for plaintiff.

14. On May 21, 1998, plaintiff s application for disability with the Social Security Administration was approved. The Administration awarded plaintiff a lump sum of $17,120, resulting in defendants' overpayment to plaintiff for 1997-98 in the amount of $14,960.16.

15. On May 26, 1998, plaintiff notified Ms. Ward that he was appealing CNA's decision to

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3 Ms. Barresi was not the original nurse case manager on plaintiff s case but was assigned to his case sometime before May 1998.



stop his benefits. In a letter to plaintiff dated May28, 1998, Ms.Ward acknowledged the receipt of plaintiff's notice of appeal and forwarded plaintiff's file to CNA's appeals committee. This letter informed plaintiff that CNA had "not received medical documentation beyond [April 13, 1998]."

16. On June 1, 1998, Ms. Barresi faxed to Dr. Booth for his approval a confirmation and summary of their May 20, 1998 conversation. This summary stated (1) that Dr. Booth was familiar with plaintiffs job requirements, (2) that plaintiff's diabetes and blood pressure were well controlled, (3) that plaintiff s depression was under control, and (4) that it would be therapeutic for plaintiff to return to work.

17. Later that same day, Dr. Booth returned the taxed confirmation, but with significant modifications to Ms. Baressi's notes. He wrote that plaintiff s blood pressure and diabetes were "fairly" controlled, that plaintiff's depression "is not well controlled," and that it would only be therapeutic for plaintiff to return to work "if he could. He is not able to return to work at this time because of his depression [and]

inability to concentrate."' Dr. Booth also noted that his opinion had changed since May 20, 1998 and that he apologized for the inconvenience.

18. Dr. Booth also sent Ms. Barresi a letter dated June 1, 1998 informing her that he had e valuated plaintiff on May 21, 1998, the day after their earlier conversation. The letter states:

> Plaintiff continues to be significantly symptomatic from his sarcoid arthritis, his sarcoid shortness of breath and lung disease and depression. Unfortunately, he is unable to perform the duties of a cardiac catheterization lab technician largely due to his depression and his inability to concentrate and carry out his duties. It is felt that there would be undue risk to patients under his care.
>
> Fortunately, his depression has improved, but only somewhat. His medications have been increased to treat his depression.

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4 This letter lists another reason why plaintiff could not return to work but the handwriting, ' '
is illegible



> Due to his sarcoid arthritis and his severe dyspnea,5 magnified by his sarcodosis, despite having relatively clear lung fields, he is unable to perform any heavy meaningful work.

19. All of the aforementioned correspondence was before the appeals committee. In addition, plaintiff submitted to the appeals committee a letter from the South Carolina Vocational Rehabilitation Center, a case synopsis of the Social Security adjudication officer, and a typewritten list entitled "Sarcoidosis and its Symptoms." He did not, however, submit further medical documentation.

20. On August 5, 1998, CNA's appeals committee notified plaintiff that his appeal was denied. The letter states that the reason for denial was the lack of objective evidence in the record that would verify plaintiff's status as totally disabled.

21. At no time before, during, or after the appeal did CAN order an in dependent examination of plaintiff as it was authorized to do under the policy.

22. On December 16, 1998, plaintiff filed suit against defendants, and on May 4, 1999, his attorney, Scott Kozacki, served a discovery request for production on defendants, including Quorum. In paragraph 8 of the request, plaintiff requested "[t]he governing Summary Plan Description(s) of Plaintiff's at issue [sic] long term disability claim." At no time prior to this request had plaintiff requested a copy of the plan in writing.

23. Mr. Kozacki subsequently stopped practicing law, and on August 20, 1999, the Court granted Mr. Kozacki's request to withdraw as counsel. On October 4, 1999, plaintiff, through his new counsel, Chalmers Johnson, served on Quorum a second request for production. In paragraph

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5 Dyspnea is abnormal or uncomfortable breathing.



3 of the request, plaintiff requested "any and all documentation provided to the Plaintiff by this Defendant outlining the provisions, terms, and conditions of The Carolina Hospital Systems Group Long Tern Disability Plan." The scheduling order then in effect, however, provided that discovery was to be closed on October 1, 1999. Quorum did not send plaintiff a copy of the plan.

24. A new scheduling order was later signed by the Court, and on April 10, 2000, plaintiff again served a request for production of the plan. On May 9, 2000,

Thomas W. McGee, attorney for defendants mailed a copy of the plan to Mr. Johnson.

## II. CONCLUSIONS OF LAW

1. Plaintiff brought his claims in state court and defendant timely removed the action to federal court. The Court therefore has federal question jurisdiction over this ERISA claim pursuant to 28 U.S.C. §§ 1441 and 1331.

2. An insurance policy is governed by ERISA if it is maintained by an employer for the purpose of providing benefits for its participants Or their beneficiaries in the event of sickness, accident, disability, death or unemployment. See 29-U.S.C§1002. Plaintiffs policy is governed by ERISA.

3. The policy grants defendants discretion to determine eligibility for benefits. Plaintiff has made no real argument that defendants were operating under a conflict of interest, and the record appears to be silent on this point. The Court will therefore examine defendant's actions under an abuse of discretion standard of review. See Booth v. Wal-Mart Stores, Inc., 201 F.3d 335, 340-341 (4th Cir. 2000).

4. Under this standard of review, the Court will not disturb the administrator's or



fiduciary's decision if reasonable, even if the Court itself, upon examining the evidence, would have reached a different conclusion. See id. "[A] decision is reasonable if it is the result of a deliberate, principled reasoning process and if it is supported by substantial evidence." Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228, 232 (4th Cir. 1997).

5. Ms. Ward's decision to terminate plaintiff s benefits was grounded on two interrelated reasons: (1) the lack of current medical documentation on file and (2) the supposed ambiguity in Dr. Booth's April 13, 1998 report.

6. With regard to the first reason, plaintiff submitted medical documentation in support of his initial

claim for disability. When it initially approved plaintiff for disability payments on April II, 1997, however, CNA instructed plaintiff that in order to maintain his classification of "disabled" under the policy, he needed to "have the claim report completed as required and return it ... when requested." It gave him no indication at that time that he would ever be required again to produce any documentation supporting his claim for disability other than the claim report, and he did not do so for the time period of 1997-98. CNA's decision on May 15, 1998 to deny plaintiff s further benefits based on the lack of medical documentation was therefore an abuse of discretion.

7. With regard to the second reason, Ms. Ward's denial of plaintiff's benefits was based on portions of Dr. Booth's report that favored terminating his benefits. She ignore ever, those portions of Dr. Booth's report that favored continuing plaintiff s benefits, the most important of which was Dr. Booth's determination that plaintiff was disabled. This decision, made without the benefit of an independent examination, was an abuse of discretion. See Salley v. Dppont, 966 F.2d 1011 (5th Cir. 1992) ("Because they chose to follow [plaintiff's physician's]



diagnosis, [the insurer was] required to follow all of his advice, not just part of it.").

8. On May 15, 1998, CNA requested medical evidence documenting plaintiff s condition. This request was appropriate. See Gooden v. Provident Life & Accident Ins. Co., 250 F.3d 329, 335 (5th Cir. 2001). An insurer must be allowed to hold plaintiff to his burden of proving he falls within the confines of the policy. Plaintiff, however, did not supply CNA with any medical evidence supporting Ms claim for continued disability, but instead attempted to gain reversal of CNA's denial of benefits by a phone call and a letter from Dr. Booth. CNA did not, therefore, abuse its discretion by ultimately denying plaintiffs benefits on August 5, 1998. See id. (finding no abuse of discretion upon termination where

insurer requested and insured did not provide medical records).

9. Plaintiff is not entitled to the equitable relief he requests under 29 U.S.C. § 1132(a)(3)-to be reinstated under the plan-because CNA did not ultimately abuse its discretion in terminating his benefits.

10. ERISA provides that "[t]he administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest UP dated summary plan description." 29 U.S.C. 1024(b)(4). It further provides that if the administrator fails to supply the requested information within 30 days, he may be liable, at the Court's discretion, to the participant in the amount of up to $100.00 per day. See29U.S.C.§1132(c)(1).

11. Complaints and requests for production are not "written requests [of administrators]" under the terms of § 1024(d)(4). See Verkullen v. South Shore Building and Mortgage Co., 122 F.3d 410 (7th Cir. 1997). Complaints are not "requests," and Courts are not "plan administrators." Id. And while requests for production directed at the administrator's attorneys



do request plans in fact, the purpose of § 1024(d)(4) is to "ensure that potentially legitimate claimants can get the information they need to determine whether they are in fact entitled to benefits." Davis v. Featherstone, 97 F.3d 734, 737 (4th Cir. 1996). Discovery requests, which are initiated only after insured's decide to assert their rights to benefits by suit, plainly do not further this goal.

12. Even if complaints and requests for production can be considered "written requests" for purposes of § 1024(b)(4), an award under that section requires an analysis of (1) prejudice to the plaintiff and (2) the defendant's bad faith. See Sedlack v. Braswell Services Group, Inc., 134 F.3d 219 (4th Cir. 1998); Davis 97 F.3d 737. There is no evidence in the record to support either prejudice or bad faith.

13. The Court may, in its discretion, award attorneys fees and costs under ERISA. See 29 U.S.C. § 1132(g)(1);

Quesinberry v. Life Ins. Co. of North America, 987 F.2d 1017,1028-29 (4th Cir. 1993).' Factors guiding the Court's discretion include:

(1) The degree of defendants' bad faith.
(2) The defendants' ability to satisfy an award of attorney's fees.
(3) Whether an award of attorney's fees would deter other persons from acting under similar circumstances.
(4) Whether the plaintiff s claim would benefit all participants and beneficiaries of the plan or resolve a significant legal question regarding ERISA itself (5) The relative merits of the parties' positions.

Id. at 1029. See also Reinking v. Philadephia American Life Ins. Co., 91 0 F.2d 1210, 1217-19 (4th Cir. 1990), overruled in part by Quesinberry, 987 F.2d 1017. There is no presumption that

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6 Quesinbegy dealt only with fees, not costs. But its five-factored approach interpreted § 1132(g)(1),the section that provides for both fees and costs. The Court will, therefore, apply Quesinberry's approach to costs as well as fees.



fees and costs are appropriate for a prevailing plaintiff. See Quesinberry, 987 F.2d at 1029. 14. The Court has found that CNA, through the actions of Ms. Ward, abused its discretion under the plan. The appeals committee, however, which sought only verifiable information regarding plaintiff s claim, did not abuse its discretion in affirming Ms. Ward's decision. It would have been wiser for CNA to allow plaintiff to continue receiving benefits for a reasonable time to allow him to gather medical records, but the Court does not think that CNA's actions support an award of fees.

15. The record is devoid of evidence regarding defendants' ability to pay an award of attorney's

fees. This Court will therefore not consider this factor in its fee analysis.

16. Any monetary Judgment against defendants will likely encourage them to counsel their employees either (1) clearly to inform their insureds what is required of them to maintain benefits or (2) give their insureds ample time to make such a showing once such a request is made. This factor weighs in plaintiff s favor.

17. Plaintiff's claims deal with no issues of great import to other potential plaintiffs. While plaintiff s second claim, that for damages under 29 U.S.C. § 1024(b)(4) for failure to produce plan documents pursuant to discovery requests, is relatively novel, potential plaintiffs' ability to obtain such documents through other means precludes the claim from being an important one. This factor too weighs in defendant's favor.

18. Plaintiff prevailed in part on one of his causes of action, and defendant prevailed on the other. Plaintiff s recovery, however, will be limited to the time after Ms. Ward's unlawful decision to terminate his benefits and before CNA's appeals committee decided plaintiff s claim. This factor also favors defendant.

19. Applying each factor, the Court determines that plaintiff is not entitled to attorney's fees. See Quesinberry, 987 F,2d at 1030 (upholding district court's denial of fee award where only one factor weighed in plaintiff's favor).

20. Plaintiff is, therefore, entitled to his $2,342.08 monthly payment for the time periods of May 18, 1998 to June 17, 1998, June 18, 1998 to July 17, 1998, and a pro rata amount of his payment for the 18-day time period from July 18, 1998 to August 5, 1998, for a total of $6,044.08.

21. ERISA does not provide for the award of pre-judgment interest, but the Court may grant such an award in its discretion. See Quenisberry, 987 F.2d at 1032. The interest rate is also left to the Court's discretion. See id. Because plaintiff was denied the use of these funds from the date of CNA's denial of his benefits, the Court will award plaintiff pre-judgment interest at the rate

prescribed in 28 U.S.C. § 1961 for use with post-judgment interest.'

**AND IT IS SO ORDERED.**

Weston C. Houck
United States
District Judge

January 14, 2003
Florence, SC

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7 Post-judgment interest is to be entered on the entire amount of plaintiff's recovery, including prejudgment interest. See Quenisberry 987 F.2d at 1034.

**APPENDIX C– ORDER FROM U.S. DISTRICT COURT,**
**JUDGE WESTON HOUCK, ENTERED MAY 14 2003**

**FILED**
**MAY 14 2003**
LARRY W. PROPES, CLERK OF COURT

IN **THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF SOUTH CAROLINA**
**FLORENCE DIVISION**

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| **LEON HARRELL,** | ) |
| | ) |
| **Plaintiff,** | )**Civil Action No. 4:99-0292-12** |
| | ) |
| VS. | ) |
| | ) |
| **CNA INSURANCE COMPANIES,** | ) **ORDER** |
| **CONTINENTAL CASUALTY COMPANY,** | ) |
| **QUORUM HEALTH GROUP, INC.,** | ) |
| **AND QHG OF SOUTH CAROLINA, INC.,** | ) |
| **both d/b/a CAROLINA'S HOSPITAL** | ) |
| **SYSTEM GROUP LONG TERM** | ) |
| **DISABILITY PLAN** | ) |
| | ) |
| **Defendant.** | ) |
| | ) |

This matter is before the Court on the plaintiff's motion to alter or amend the Court's order of January 16, 2003. For the reasons that follow, the Court denies the motion.

On December 16, 1998, Leon Harrell ("Plaintiff') brought this claim alleging two causes of action against CNA Insurance Companies, Continental Casualty Company, Quorum Health Group, Inc., and QHG of South Carolina, Inc. "Defendants"). The plaintiff's causes of actions were for violations of 29 U.S.C. §§ 1132(c)(1) and (a)(1).

The parties agreed to try the case on submissions. OnJanuary16,2003,theclerk,entered an order containing findings of fact and conclusions of law whereby the Court (1) granted judgment to the defendant on the plaintiff's § 1024(b)(4) claim and (2) granted judgment to the plaintiff on his § 1 132(a)(1) claim, although the damage award was for an amount far less than what the plaintiff sought. On January 30. 2003, the plaintiff moved under Fed. R. Civ. P. 59(e) for the Court to alter or amend its January 16, 2003 order.' The plaintiff alleged that the Court erred by: (1) failing to consider the record in applying the abuse of discretion standard of review; (2) concluding the administrator's decision was reasonable; (3) finding that discovery requests are not "requests" as that term is used in § 1024(b)(4); and (4) failing to award attorney's fees.

A Rule 59(e) motion seeks an extraordinary remedy that district courts should use sparingly. See Pacific Insurance Co. v. American N itional Fire InLurance Co., 148 F.3d 396, 403 (4th Cir. 1998). Indeed, the Fourth Circuit recognizes but three grounds for a Rule 59(e) motion: (1) to accommodate an intervening change in controlling law; (2) to account for new evidence not available at trial; or (3) to correct a clear error of law or prevent manifest injustice. See id. at 402; EEOC v. Lockheed Martin Corp. 116 F.3d 110, 112 (4th Cir. 1997); Hutchinson v. Staton, 994 F.2d 1076, 1081 (4thClr. 1993). Theplaintiff's motion alleges that the Court's January 16,2003 order contains clear errors of law. The Court disagrees.

First. The plaintiff argues that the Court erred by failing to consider the record in applying the abuse of discretion standard of review. The January 16, 2003 order makes clear, however, that the Court did independently review the record despite the fact that the plaintiff made no argument in his trial

submissions that the defendants were operating under a conflict of interest. That order states:

> The policy grants defendants discretion to determine eligibility for benefits. Plaintiff has made no real argument that defendants were operating under a conflict of interest, and the record appears to be silent on this point. The Court will therefore examine defendant's actions under an abuse of discretion standard of review. See Booth v. Wal-Mart Stores, Inc., 201 F.3d 335, 340-341 (4th Cir. 2000).

Order of January 16, 2003 Section 11 at 1 3 (emphasis added). As this paragraph makes clear, the Court independently reviewed the record and found no conflict of interest. [2]

Second. The plaintiff argues that the Court erred by concluding the administrator's decision was reasonable. In particular, he first argues that CNA's decision did not comport with the procedural and substantive requirements of Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228, 232 (4th Cir. 1997). Second, he argues that both the appeal board's and the Court's

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1 The plaintiff's motion is styled as a motion for reconsideration. The Federal Rules make no provision for such a motion. Instead, Rule 59(e) allow a party to bring a motion to alter or amend judgment. The Court will interpret the plaintiff s motion for reconsideration as a Rule 59(e) motion to alter or amend judgment.

failure to credit Dr. Booth's June 1, 1998 letter was in error.

With respect to the plaintiff s first argument, the Court has reviewed the record and determines again, and for the same reasons as stated in the January 16, 2003 order, that the appeals board's decision was reasonable. [3] With respect to the second argument, it is clear that both the appeals board and the Court examined 'Dr. Booth's letter. The letter, however, contained only conclusory statements unaccompanied by supporting evidence documenting the plaintiff's disability. It was not error to give little, if any, weight, to the letter. [4]

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[2] Moreover, while the plaintiff now argues for the first time that CNA had a conflict of interest because its appeals board was comprised of its own employees, he cites no law in support of this startling proposition. Cf Doe v. GroM Hospitalization & Medical Services, 3 F.3d 80, 86 (4th Cir. 1993) (conflict of interest exists where plan insurer is also its administrator and insurer/administrator therefore has incentive to deny claims).

[3] The plaintiff also argues the Court erred by failing to apply the treating physician rule. Notwithstanding the fact that Fourth Circuit has not adopted this doctrine, see Elliot v. Sara Lee Co., 190 F.3d 601 (4th Cir. 1999), given the ambiguities in Dr. Booth's report and the lack of medical evidence supporting the plaintiff s disability, its application would have made no difference in this case.

[4] The plaintiff also argues that the appeal board's decision not to credit Dr. Booth's letter rendered other plan provisions meaningless. In particular, the plaintiff argues that if the appeal board

can discount Dr. Booth's letter, it renders meaningless the provision allowing CNA to



Third. The Plaintiff argues that the Court erred by finding that discovery requests are not &requests" as that term is used in § 1024(b)(4). As the court in Verkuilen v. South Shore Building And Mortgage Co. noted, however, treating discovery requests as "requests" ignores the point that

> one must have a grievance before commencing suit; delay in responding to a ... discovery request can't logically be what the case is about. Unless the parties have a dispute predating the [discovery request], there is nothing to litigate about[:] unless the participant made a request in writing to the plan administrator more than 30 days before filing the complaint, there is no case or controversy; and if the written request was made, there is no need to treat the [discovery request] as a [§ 1024(b)(4)] request.

122 F.3d 410, 41@ 1 (7th Cir. 1997) (emphasis in original)., The Court's finding was not erroneous.5

Fourth. The plaintiff argues that the Court erred by failing to award attorney's fees. The Court has reconsidered its decision and again denies the request for an award of attorney's fees for the same reasons as announced in its January 16, 2003 order.

For the foregoing reasons, the plaintiff s motion is denied.

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conduct its own independent examination of its insureds. This argument, however, is without merit, for it presumes

that CNA's independent examination would necessarily produce nothing but an unsupported letter.

5 The plaintiffs other arguments regarding his § 1024(b)(4) claim are therefore rendered moot.



**AND IT IS SO ORDERED.**

C. Weston Houck
United States District Judge

May 14, 2003
Florence, SC

**APPENDIX D – ORDER FROM U.S. DISTRICT COURT, JUDGE WESTON HOUCK, ENTERED JANUARY 16, 2003**

FILED
MAY 15 2003
LARRY W. PROPES
CLERK OF COURT,
FLORNECE SC

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF SOUTH CAROLINA**
**FLORENCE DIVISION**

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|---|---|
| **LEON HARRELL,** | ) |
| | ) |
| **Plaintiff,** | )**Civil ActionNo. 4:99-0292-12** |
| | ) |
| VS. | ) |
| | ) |
| **CNA INSURANCE COMPANIES, CONTINENTAL CASUALTY COMPANY, QUORUM HEALTH GROUP, INC., AND QHG OF SOUTH CAROLINA, INC., both D/b/a CAROLINA'S HOSPITAL SYSTEM GROUP LONG TERM DISABILITY PLAN,** | )<br>)**AMENDED**<br>)**JUDGMENT**<br>)**IN A CIVIL**<br>)**CASE**<br>)<br>)<br>)<br>)<br>) |
| **Defendant.** | ) |

[ ] Jury Verdict. This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

[X] Decision by Court. This action came before the Court on the parties agreement to try plaintiffs claims on submissions. The issues have been tried and a decision has been rendered,

**IT IS ORDERED AND ADJUDGED** that judgment is entered for the plaintiff Leon Harrell in the amount of Six Thousand, Forty-Four and 08/100 ($6,044.08) Dollars plus prejudgment interest at the rate prescribed in 28 U.S.C. § 1961 for the time periods of May 18, 1998 to June 17, 1998, June 18, 1998 to July 17, 1998 and July 18, 1998 to August 5, 1998 together with post judgment interest on the entire amount of plaintiff's recovery, including pre judgment interest.

IT IS FURTHER ORDERED that summary judgment having previously been granted on defendants' counterclaim, that defendants CNA Insurance Companies, Continental Casualty Company, Quorum Health Group, Inc., and QHG of South Carolina, Inc., both d/b/a Carolina's
Hospital System Group Long Term Disability Plan recover of the Plaintiff Leon Harrell Fourteen Thousand, Nine Hundred Seventy and 16/100 ($14,970.16) Dollars (the amount of Social Security Benefits received by plaintiff while he received benefits from CNA), plus interest in the amount of Four Thousand, Eight Hundred Eighteen and 91/100 ($4,818.9 1) Dollars and attorneys' fees in the amount of Two Thousand, Three Hundred Twenty-Four ($2,324.00) Dollars for a total of Twenty Two Thousand, One Hundred Thirteen and 07/100 ($22,113.07) Dollars, and this action is hereby dismissed.

LARRY W. PROPES, Clerk
By _____
Deputy Clerk

May 15, 2003